

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7676

State File No. _____

FILED MAR 11 1943

Registration District No. _____

Primary Registration District No. 200

Registrar's No. 289

1. PLACE OF DEATH
(a) County St. Louis
(b) City or town St. Mary
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mount St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11/14/42 to 2/4/43
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SIMON PARRES
(b) If veteran, name war _____ (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Julia Moore (c) Age of husband or wife if alive 53 years
7. Birth date of deceased January 26, 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 8 If less than one day hr. min.

9. Birthplace Perry County, Mo.
(City, town or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Parres
13. Birthplace Perry County, Mo.
(City, town or county) (State or foreign country)
14. Maiden name Cora Nash
15. Birthplace Perry County, Mo.
(City, town or county) (State or foreign country)

16. (a) Informant Mrs. Simon Parres
(b) Address St. Mary, Mo.

17. (a) Burial (b) Date thereof Feb. 8, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Bey Funeral Home
(b) Address Perryville, Mo.

19. (a) FEB 6 1943 (b) J. E. McFarland
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Genevieve
(c) City or town St. Mary
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4 year 1943 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 11/21 1942 to 2/4 1943
that I last saw him alive on 2/4 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis Duration 3 yrs.

Due to: _____

Due to: _____

Other conditions arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: cardiovascular disease PHYSICIAN _____
Of operations _____

Of autopsy 13 ft Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature John C. Murphy (M. D. or other) M.D.
Address 9101 S. Broadway Date signed 2/4/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Albert Bey
.....
Licensed Embalmer No. *3866*

P. O. Address *Perryville, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.